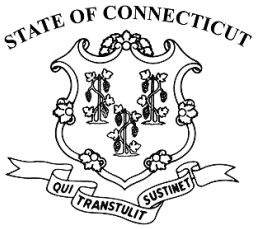

Substitute House Bill No. 5205

Public Act No. 18-13

AN ACT CONCERNING THE CONNECTICUT LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-859 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

To provide protection for **[**policyowners, insureds, beneficiaries, annuitants, payees and assignees of life insurance policies, health insurance policies, annuity contracts, and supplemental contracts**]** persons covered under section 38a-860, as amended by this act, subject to certain limitations, against failure in the performance of contractual obligations under life, health and annuity policies, plans or contracts specified in section 38a-860, as amended by this act, due to the impairment of the insurer issuing such policies, plans or contracts, an association of member insurers is created to enable the guaranty of payment of benefits and of continuation of coverages. Members of the association are subject to assessment to provide funds to carry out the purpose of sections 38a-858 to 38a-875, inclusive, and the association is authorized to assist the commissioner in the prescribed manner in the detection and prevention of insurer impairments.

Sec. 2. Section 38a-860 of the general statutes is repealed and the

following is substituted in lieu thereof (*Effective July 1, 2018, and applicable to impairments and insolvencies occurring on or after said date*):

(a) Sections 38a-858 to 38a-875, inclusive, shall provide coverage for the policies and contracts specified in subsection (f) of this section: (1) To any person, except for a nonresident certificate holder under a group policy or contract, who is the beneficiary, assignee or payee, including a health care provider rendering services covered under a health insurance policy or certificate, of the person covered under subdivision (2) of this subsection, regardless of where the person resides, and (2) any person who is the owner of, or certificate holder or enrollee under, such policy or contract, other than an unallocated annuity contract or a structured settlement annuity, and in each case who (A) is a resident, or (B) is not a resident, provided (i) the member insurer that issued such policy or contract is domiciled in this state, (ii) the state in which the person resides has an association similar to the association created by this section and sections 38a-837, 38a-838, 38a-845, 38a-853, 38a-859, as amended by this act, 38a-862, as amended by this act, 38a-863, as amended by this act, 38a-865, as amended by this act, and 38a-866, as amended by this act, and (iii) the person is not eligible for coverage by an association in any other state because the insurer was not licensed in the state in which the person resides at the time specified in the state's guaranty association law.

(b) For unallocated annuity contracts specified in subsection (f) of this section, subdivisions (1) and (2) of subsection (a) of this section shall not apply, and except as provided in subsections (d) and (e) of this section, sections 38a-858 to 38a-875, inclusive, shall apply to: (1) Any person who is the owner of the unallocated annuity contract if the contract is issued to, or in connection with, a specific benefit plan whose plan sponsor has its principal place of business in this state; and (2) any person who is the owner of an unallocated annuity contract issued to, or in connection with, government lotteries if the owners are

residents.

(c) For structured settlement annuities specified in subsection (f) of this section, subdivisions (1) and (2) of subsection (a) of this section shall not apply, and except as provided in subsections (d) and (e) of this section, sections 38a-858 to 38a-875, inclusive, shall apply to a person who is a payee under a structured settlement annuity, or to a person who is a beneficiary of a payee if the payee is deceased, if the payee: (1) Is a resident, regardless of where the contract owner resides, or (2) is not a resident, provided: (A) (i) The contract owner of the structured settlement annuity is a resident, or (ii) the contract owner of the structured settlement annuity is not a resident, but the insurer that issued the structured settlement annuity is domiciled in this state, and the state in which the contract owner resides has an association similar to the association created by sections 38a-858 to 38a-875, inclusive; and (B) neither the payee, beneficiary or contract owner is eligible for coverage by the association of the state in which the payee, beneficiary or contract owner resides.

(d) Sections 38a-858 to 38a-875, inclusive, shall not provide coverage to: (1) A person who is a payee or beneficiary of a contract owner resident of this state, if the payee or beneficiary is afforded any coverage by the association of another state; **[**or**]** (2) a person covered under subsection (b) of this section, if any coverage is provided by the association of another state to the person; or (3) a person who acquires rights to receive payments through a structured settlement factoring transaction as defined in 26 USC 5891(c)(3)(A), regardless of whether the transaction occurred before, on or after the date 26 USC 5891 (c)(3)(A) became effective.

(e) Sections 38a-858 to 38a-875, inclusive, shall provide coverage to a person who is a resident and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under sections 38a-858 to 38a-875,

inclusive, is provided coverage under the laws of any other state, the person shall not be provided coverage under sections 38a-858 to 38a-875, inclusive. In determining the application of the provisions of this subsection in situations where a person could be covered by the association of more than one state, whether as an owner, payee, enrollee, beneficiary or assignee, sections 38a-858 to 38a-875, inclusive, shall be construed in conjunction with the laws of other states to result in coverage by only one association.

(f) (1) Sections 38a-858 to 38a-875, inclusive, shall provide coverage to the persons specified in subsections (a) to **[**(d)**]** (e), inclusive, of this section for policies or contracts of direct, nongroup life insurance, health insurance, or **[**annuity policies or contracts**]** annuities and supplemental contracts to such policies or contracts, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by said sections. Annuity contracts and certificates under group annuity contracts include, but are not limited to, guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, annuities issued to or in connection with government lotteries and any immediate or deferred annuity contracts.

(2) Sections 38a-858 to 38a-875, inclusive, shall not provide coverage for: (A) Any portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract holder; (B) any policy or contract of reinsurance, unless assumption certificates have been issued; (C) except as set forth in subdivision (3) of this subsection, any portion of a policy or contract to the extent that the rate of interest on which it is based or the interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value (i) averaged over the period of four years

prior to the date on which the member insurer becomes an impaired or insolvent insurer under sections 38a-858 to 38a-875, inclusive, exceeds the rate of interest determined by subtracting two percentage points from Moody's corporate bond yield average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four years before the member insurer becomes an impaired or insolvent insurer under sections 38a-858 to 38a-875, inclusive, whichever is earlier, and (ii) on and after the date on which the member insurer becomes an impaired or insolvent insurer under sections 38a-858 to 38a-875, inclusive, whichever is earlier, exceeds the rate of interest determined by subtracting three percentage points from Moody's corporate bond yield average as most recently available; (D) a portion of a policy or contract issued to any plan or program of an employer, association or similar entity to provide life, health or annuity benefits to its employees or members to the extent that such plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association or similar entity under (i) a multiple employer welfare arrangement as defined in Section 514 of the federal Employee Retirement Income Security Act of 1974, as amended from time to time, (ii) a minimum premium group insurance plan, or (iii) an administrative services only contract; (E) any stop-loss or excess loss insurance policy or contract providing for the indemnification of or payment to a policy owner, a contract owner, a plan or another person obligated to pay life, health or annuity benefits; (F) any portion of a policy or contract to the extent that it provides dividends, experience rating credits, voting rights or provides that any fees or allowances be paid to any person, including, but not limited to, the policy or contract holder, in connection with the service to or administration of such policy or contract; (G) any policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue such policy or contract in this state; (H) any unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit

Guaranty Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet become liable to make any payments with respect to the benefit plan; (I) any portion of an unallocated annuity contract that is not issued to, or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery; (J) **[**any subscriber contract issued by a health care center**]** a portion of a policy or contract to the extent that the assessments required by section 38a-866, as amended by this act, with respect to the policy or contract are preempted by federal or state law; (K) a contractual agreement that establishes the insurer's obligation by reference to a portfolio of assets that is not owned or possessed by the insurance company; (L) an obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner or policy owner, including, but not limited to, (i) a claim based on marketing materials, (ii) a claim based on side letters, riders or other documents that were issued by the member insurer without meeting applicable policy contract form filing or approval requirements, (iii) a misrepresentation of or regarding policy or contract benefits, (iv) an extra-contractual claim, or (v) a claim for penalties or consequential or incidental damages; (M) a contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer; (N) a portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but that have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under sections 38a-858 to 38a-875, inclusive, whichever is earlier. If a policy's or contract's interest or changes in value are

credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this subparagraph, the interest or change in value determined by using the procedures defined in the policy or contract shall be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and shall not be subject to forfeiture; **[**and**]** (O) structured settlement annuity benefits to which a payee or beneficiary has transferred the payee's or beneficiary's rights in a structured settlement factoring transaction as defined in 26 USC 5891(c)(3)(A), regardless of whether the transaction occurred before or after said section became effective; and (P) any policy or contract providing hospital, medical, prescription drugs or other health care benefits pursuant to Part C, 42 USC 1395w21 et seq., **[**or**]** Part D, 42 USC 1395w101 et seq., or 42 USC Chapter 7, Subchapter XIX, as **[**both**]** said parts and subchapter may be amended from time to time, or any regulations issued thereunder.

(3) Subparagraph (C) of subdivision (2) of this subsection shall not apply to any portion of a policy or contract, including any rider to such policy or contract, that provides long-term care benefits or any other health insurance benefits.

(g) The benefits for which the association may become liable shall in no event exceed the lesser of: (1) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired insurer, or (2) (A) with respect to any one life, regardless of the number of policies or contracts: (i) Five hundred thousand dollars in life insurance death benefits, but no more than five hundred thousand dollars in net cash surrender and net cash withdrawal values for life insurance; (ii) five hundred thousand dollars in health insurance benefits, including, but not limited to, any net cash surrender and net cash withdrawal values; (iii) five hundred thousand dollars in the present value of annuity benefits, including, but not

limited to, net cash surrender and net cash withdrawal values; (B) with respect to each individual participating in a governmental retirement plan established under Section 401, 403(b) or 457 of the United States Internal Revenue Code of 1986, or any subsequent internal revenue code of the United States, as amended from time to time, covered by an unallocated annuity contract or the beneficiaries of each such individual if deceased, in the aggregate, five hundred thousand dollars in present value annuity benefits, including, but not limited to, net cash surrender and net cash withdrawal values; (C) with respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, five hundred thousand dollars in present value annuity benefits, in the aggregate, including, but not limited to, net cash surrender and net cash withdrawal values, if any, provided in no event shall the association be liable to expend (i) more than the five hundred thousand dollars in the aggregate with respect to any one individual under subparagraphs (A), (B) and (C) of this subdivision, and (ii) with respect to one owner of multiple nongroup policies of life insurance, whether the policy or contract owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, more than five million dollars in benefits, regardless of the number of policies and contracts held by the owner; (D) with respect to either (i) one contract owner provided coverage under subdivision (2) of subsection (b) of this section, or (ii) one plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts not included in subparagraph (B) of subdivision (2) of this subsection, five million dollars in benefits regardless of the number of contracts with respect to the contract owner or plan sponsor, except that in the case where one or more unallocated annuity contracts are covered contracts under sections 38a-858 to 38a-875, inclusive, and are owned by a trust or other entity for the benefit of two or more plan sponsors, coverage shall be afforded by the association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose

principal place of business is in this state and in no event shall the association be obligated to cover more than five million dollars in benefits with respect to all such unallocated contracts; **[**.**]**

[(h) The**]** and (E) the limits set forth in **[**subsection (g) of this section**]** this subsection are limits on the benefits for which the association is obligated before taking into account either the association's subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer that are attributable to covered policies. The costs of the association's obligations under sections 38a-858 to 38a-875, inclusive, may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to the association's subrogation and assignment rights.

(h) For purposes of sections 38a-858 to 38a-875, inclusive, benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the benefits provided under the base life insurance policy or annuity contract to which such rider relates.

(i) In performing its obligation to provide coverage under section 38a-865, as amended by this act, the association shall not be required to guarantee, assume, reinsure, reissue or perform, or cause to be guaranteed, assumed, reinsured, reissued or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that does not materially affect the economic value or economic benefit of the covered policy or contract.

Sec. 3. Section 38a-862 of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

As used in sections 38a-858 to 38a-875, inclusive:

(1) "Account" means either of the two accounts created under section 38a-863, as amended by this act;

(2) "Association" means the Connecticut Life and Health Insurance Guaranty Association created under section 38a-863, as amended by this act;

(3) "Authorized assessment" or "authorized", when used in the context of assessments, means a resolution that has been passed by the board of directors of the association whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed;

(4) "Benefit plan" means a specific employee, union or association of natural persons benefit plan;

(5) "Called assessment" or "called", when used in the context of assessments, means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth in the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers;

(6) "Commissioner" means the Insurance Commissioner of this state;

(7) "Contractual obligation" means any obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under section 38a-860, as amended by this act;

(8) **[**"Covered policy"**]** "Covered contract" or "covered policy" means any policy or contract within the scope of section 38a-860, as amended by this act;

(9) "Entity" means a person other than a natural person;

(10) "Health insurance" means a policy or contract of health insurance, including, but not limited to, a health care center subscriber contract or certificate;

[(10)**]** (11) "Impaired insurer" means a member insurer that, after October 1, 1972, is not an insolvent insurer, and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction;

[(11)**]** (12) "Insolvent insurer" means a member insurer that after October 1, 1972, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency;

[(12)**]** (13) "Member insurer" means any insurer or health care center licensed or **[**who holds**]** holding a certificate of authority to issue in this state any kind of insurance or conduct any health care center business to which sections 38a-858 to 38a-875, inclusive, apply under section 38a-860, as amended by this act, and may include an insurer or health care center whose license in this state has been suspended, revoked or voluntarily withdrawn; **[**. "Member insurer" does not include a health care center;**]**

[(13)**]** (14) "Moody's corporate bond yield average" means the monthly average corporates as published by Moody's Investors Service, Inc., or any successor thereto;

[(14)**]** (15) "Owner", "policy holder", "policy owner" or "contract owner" means the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the member insurer. "Owner", "policy holder", "policy owner" and "contract owner" **[**and

"policy owner"**]** does not include a person with a mere beneficial interest in a policy or contract;

[(15)**]** (16) "Plan sponsor" means: (A) The employer in the case of a benefit plan established or maintained by a single employer; (B) the employee organization in the case of a benefit plan established or maintained by an employee organization; or (C) in the case of a benefit plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees or other similar group of representatives of the parties who establish or maintain the benefit plan;

[(16)**]** (17) "Premiums" means amounts or considerations, by whatever name called, received on covered policies or contracts less premiums, considerations and deposits returned thereon, and less dividends and experience credits thereon. "Premiums" does not include (A) any amounts or considerations received for any policies or contracts or for the portions of any policies or contracts for which coverage is not provided under subsection (f) of section 38a-860, as amended by this act, except that (i) assessable premium shall not be reduced on account of subparagraph (C) of subdivision (2) of subsection (f) of section 38a-860, as amended by this act, relating to interest limitations, and subdivision (2) of subsection (g) of section 38a-860, as amended by this act, relating to limitations with respect to any one individual, any one participant and any one policy or contract owner, **[**; provided further,**]** and (ii) "premiums" does not include any premiums in excess of five million dollars on any unallocated annuity contract not issued under a governmental retirement benefit plan established under Section 401, 403(b) or 457 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended, or (B) with respect to multiple nongroup policies of life insurance owned by one owner,

whether the policy owner or contract owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, premiums in excess of five million dollars with respect to such policies or contracts, regardless of the number of policies or contracts held by the owner;

[(17)**]** (18) "Person" means any individual, corporation, limited liability company, partnership, association, governmental body or entity, or voluntary organization;

[(18)**]** (19) "Principal place of business" of a plan sponsor or an entity means the single state in which the natural persons who establish policy for the direction, control and coordination of the operations of the plan sponsor or entity as a whole primarily exercise that function, as determined by the association in its reasonable judgment by considering the factors set forth in subparagraphs (A) to (G), inclusive, of this subdivision: (A) The state in which the primary executive and administrative headquarters of the plan sponsor or entity is located; (B) the state in which the principal office of the chief executive officer of the plan sponsor or entity is located; (C) the state in which the board of directors, or similar governing person or persons, of the plan sponsor or entity conducts the majority of its meetings; (D) the state in which the executive or management committee of the board of directors, or similar governing person or persons, of the plan sponsor or entity conducts the majority of its meetings; (E) the state from which the management of the overall operations of the plan sponsor or entity is directed; (F) in the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the factors set forth in subparagraphs (A) to (E), inclusive, of this subdivision; and (G) notwithstanding subparagraphs (A) to (F), inclusive, of this subdivision, in the case of a plan sponsor, if more than fifty per cent of the participants in the

benefit plan are employed in a single state, that state shall be deemed to be the principal place of business of the plan sponsor. The principal place of business of a plan sponsor of a benefit plan described in subparagraph (C) of **[**subdivision (15)**]** subdivision (16) of this section shall be deemed to be the principal place of business of the association, committee, joint board of trustees or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question;

[(19)**]** (20) "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation or liquidation of the member insurer;

[(20)**]** (21) "Resident" means a person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer, whichever occurs first. A person may be a resident of only one state, which in the case of an entity shall be its principal place of business. Citizens of the United States that are either (A) residents of foreign countries, or (B) residents of United States possessions, territories or protectorates that do not have an association similar to the association created by sections 38a-858 to 38a-875, inclusive, shall be deemed residents of the state of domicile of the member insurer that issued the policies or contracts;

[(21)**]** (22) "Structured settlement annuity" means an annuity purchased to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant;

[(22)**]** (23) "Supplemental contract" means any agreement entered into for the distribution of policy or contract proceeds under a life, health or annuity policy or contract; and

[(23)**]** (24) "Unallocated annuity contract" means any annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under such contract or certificate.

Sec. 4. Subsection (a) of section 38a-863 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) There is created a nonprofit legal entity to be known as the Connecticut Life and Health Insurance Guaranty Association. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance or conduct health care center business in this state. The association shall perform its functions under the plan of operation established and approved under section 38a-867 and shall exercise its powers through a board of directors established under section 38a-864, as amended by this act. For purposes of administration and assessment, the association shall maintain two accounts:

(1) The life insurance and annuity account which includes the following subaccounts:

(A) Life insurance account;

(B) **[**annuity**]** Annuity account which shall include, but is not limited to, annuity contracts owned by a governmental retirement plan, or its trustee, established under Section 401, 403(b) or 457 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended, but shall otherwise exclude unallocated annuities; and

(C) **[**unallocated**]** Unallocated annuity account which shall exclude contracts owned by a governmental retirement benefit plan, or its trustee, established under Section 401, 403(b) or 457 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended; and

(2) **[**the**]** The health **[**insurance**]** account.

Sec. 5. Subsection (a) of section 38a-864 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) The board of directors of the association shall consist of not less than **[**five**]** seven nor more than **[**nine**]** eleven members serving terms as established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the commissioner. Vacancies on the board shall be filled for the remaining period of the term in the manner described in the plan of operation. To select the initial board of directors, and initially organize the association, the commissioner shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member insurer shall be entitled to one vote in person or by proxy. If the board of directors is not selected within sixty days after notice of the organizational meeting, the commissioner may appoint the initial members.

Sec. 6. Section 38a-865 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018, and applicable to impairments and insolvencies occurring on or after said date*):

(a) If a member insurer is an impaired insurer, the association may, in its discretion, and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer and that are approved by the commissioner: **[**,**]**

(1) **[**guarantee**]** Guarantee, assume, reissue or reinsure, or cause to be guaranteed, assumed, reissued or reinsured, any or all of the policies or contracts of the impaired insurer; or

(2) **[**provide**]** Provide such moneys, pledges, loans, notes, guarantees or other means as are proper to effectuate subdivision (1) of this subsection and assure payment of the contractual obligations of the impaired insurer pending action under subdivision (1) of this subsection.

(b) If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

(1) (A) (i) Guarantee, assume, reissue or reinsure, or cause to be guaranteed, assumed, reissued or reinsured, the policies or contracts of the insolvent insurer, or (ii) assure payment of the contractual obligations of the insolvent insurer, and (B) provide moneys, pledges, loans, notes, guarantees or other means reasonably necessary to discharge the association's duties; or

(2) Provide benefits and coverages in accordance with the following provisions:

(A) With respect to **[**life and health insurance policies and annuities**]** policies and contracts, assure payment of benefits **[**for premiums identical to the premiums and benefits, except for terms of conversion and renewability**]** that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred: (i) With respect to group policies and contracts, not later than the earlier of the next renewal date under those policies or contracts or forty-five days, but in no event less than thirty days after the date on which the association becomes obligated with respect to the policies and contracts; (ii) with respect to nongroup policies, contracts and annuities, not later than the earlier of the next renewal date, if any, under the policies or contracts

or one year, but in no event less than thirty days from the date on which the association becomes obligated with respect to the policies or contracts;

(B) Make diligent efforts to provide all known insureds, enrollees or annuitants, for nongroup policies and contracts, or group policy or contract owners with respect to group policies and contracts, thirty days' notice of the termination of benefits pursuant to subparagraph (A) of this subdivision;

(C) With respect to nongroup **[**life and health insurance policies and annuities**]** policies and contracts covered by the association, make available to each known insured or annuitant, or owner if other than the insured, enrollee or annuitant, and with respect to an individual formerly an insured, enrollee or **[**formerly an**]** annuitant under a group policy or contract who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subparagraph (D) of this subdivision, if the insureds, enrollees or annuitants had a right under law or the terminated policy, contract or annuity to convert coverage to individual coverage or to continue an individual policy, contract or annuity in force until a specified age or for a specified time during which the insurer or health care center had no right to make unilateral changes in any provision of the policy, contract or annuity or had a right only to make changes in premium by class;

(D) In providing the substitute coverage required under subparagraph (C) of this subdivision, the association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates. Alternative or reissued policies shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy or contract. The association may reinsure any alternative or reissued policy or contract;

(E) Alternative policies or contracts adopted by the association shall be subject to the approval of the **[**domiciliary insurance**]** commissioner. **[**and the receivership court.**]** The association may adopt alternative policies or contracts of various types for future issuance without regard to any particular impairment or insolvency;

(F) Alternative policies or contracts adopted by the association shall contain at least the minimum statutory provisions required in this state and provide benefits that **[**shall not be**]** are not unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates that it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy or contract was last underwritten;

(G) Any alternative policy or contract issued by the association shall provide coverage of a type similar to that of the policy or contract issued by the impaired or insolvent insurer as determined by the association;

(H) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy or contract, the premium shall be actuarially justified and set by the association in accordance with the amount of insurance or coverage provided and the age and class of risk, subject to prior approval of the **[**domiciliary insurance**]** commissioner; **[**and the receivership court;**]**

(I) The association's obligations with respect to coverage under any policy or contract of the impaired or insolvent insurer or under any reissued or alternative policy or contract shall cease on the date the coverage or policy or contract is replaced by another similar policy or contract by the owner, the insured, the enrollee or the association;

(J) When proceeding under this subdivision with respect to a policy

or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with subparagraph (C) of subdivision (2) of subsection (f) of section 38a-860, as amended by this act.

(c) Nonpayment of premiums by the thirty-first day after the date required under the terms of any guaranteed, assumed, alternative or reissued policy or contract or substitute coverage shall terminate the association's obligations under the policy, contract or coverage under sections 38a-858 to 38a-875, inclusive, with respect to the policy, contract or coverage, except with respect to any claims incurred or any net surrender value that may be due in accordance with the provisions of sections 38a-858 to 38a-875, inclusive.

(d) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association, and the association shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order.

(e) The protection provided by sections 38a-858 to 38a-875, inclusive, shall not apply where any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

(f) Repealed by P.A. 87-290, S. 7, 8.

(g) In carrying out its duties under subsection (b) of this section, the association may:

(1) Subject to approval by a court in this state, impose permanent policy or contract liens in connection with a guarantee, assumption or reinsurance agreement, if the association finds that the amounts which can be assessed under sections 38a-858 to 38a-875, inclusive, are less than the amounts needed to assure full and prompt performance of the

association's duties under sections 38a-858 to 38a-875, inclusive, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens to be in the public interest;

(2) Subject to approval by a court in this state, impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(h) If the association fails to act within a reasonable period of time with respect to any insolvent insurer, as provided in subsection (b) of this section, the commissioner shall have the powers and duties of the association under sections 38a-858 to 38a-875, inclusive, with respect to the insolvent insurer.

(i) The association may render assistance and advice to the commissioner, upon the commissioner's request, concerning rehabilitation, payment of claims, continuation of coverage, or the performance of other contractual obligations of an impaired or insolvent insurer.

(j) The association shall have standing to appear or intervene before

a court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under sections 38a-858 to 38a-875, inclusive, or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. Such standing shall extend to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring, reissuing, modifying or guaranteeing the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise.

(k) (1) A person receiving benefits under sections 38a-858 to 38a-875, inclusive, whether the benefits are payments of or on account of contractual obligations, continuation of coverage or provision of substitute or alternative policies, contracts or coverages, shall be deemed to have assigned (A) the rights under the covered policy or contract to the association to the extent of the benefits received under sections 38a-858 to 38a-875, inclusive, and (B) any causes of action against any person for losses arising under, resulting from or otherwise relating to, the covered policy or contract to the association to the extent of the benefits received because of sections 38a-858 to 38a-875, inclusive. The association may require an assignment to it of such rights or cause of action by any enrollee, payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any right or benefits under sections 38a-858 to 38a-875, inclusive, upon the person.

(2) The subrogation rights of the association under this subsection shall have the same priority against the assets of the impaired or

insolvent insurer as that possessed by the person entitled to receive benefits under sections 38a-858 to 38a-875, inclusive.

(3) In addition to subdivisions (1) and (2) of this subsection, the association shall have, originally or by succession, all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, enrollee or payee of a policy or contract with respect to the policy or contracts, against a person responsible for the losses arising from the personal injury relating to the annuity or payment thereof, except any such person responsible solely by reason of serving as an assignee with respect to a qualified assignment under Section 130 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended. Such rights of the association shall include, but are not limited to, in the case of a structured settlement annuity, any rights of the owner, beneficiary or payee of the annuity, to the extent of benefits received pursuant to sections 38a-858 to 38a-875, inclusive.

(4) If the provisions of subdivisions (1) to (3), inclusive, of this subsection are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies or contracts, or portion thereof, covered by the association.

(5) If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in subdivisions (1) to (4), inclusive, of this subsection, the person shall pay to the association the portion of the recovery attributable to the policies or contracts, or portion thereof, covered by the association.

(l) In addition to the rights and powers **[**elsewhere**]** otherwise provided in sections 38a-858 to 38a-875, inclusive, the association may:

(1) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of sections 38a-858 to 38a-875, inclusive;

(2) Sue or be sued, including, but not limited to, taking any legal actions necessary or proper to recover any unpaid assessments under section 38a-866, as amended by this act, and to settle claims or potential claims against it;

(3) Borrow money to effect the purposes of sections 38a-858 to 38a-875, inclusive, and any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic member insurers and may be carried as admitted assets;

(4) Employ or retain such persons as are necessary or proper to handle the financial transactions of the association, and to perform such other functions as become necessary or proper under sections 38a-858 to 38a-875, inclusive;

(5) Take such legal action as may be necessary or proper to avoid or recover payment of improper claims;

(6) Exercise, for the purposes of sections 38a-858 to 38a-875, inclusive, and to the extent approved by the commissioner, the powers of a domestic life **[**or**]** insurer, health insurer or health care center, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform its obligations under sections 38a-858 to 38a-875, inclusive;

(7) Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under sections 38a-858 to 38a-875, inclusive, with respect to the person, and the person shall promptly comply with the request;

[and**]**

(8) Unless otherwise prohibited by law, file for an actuarially justified rate or premium increase for any policy or contract for which the association provides coverage under sections 38a-858 to 38a-875, inclusive, provided such increase is in accordance with the terms and conditions set forth in such policy or contract; and

[(8)**]** (9) Take other necessary or proper action to discharge its duties and obligations under sections 38a-858 to 38a-875, inclusive, or to exercise its powers under sections 38a-858 to 38a-875, inclusive.

(m) The association may join an organization of one or more other state associations of similar purposes to further the purposes and administer the powers and duties of the association.

(n) (1) At any time within one year after the date on which the association becomes responsible for the obligations of a member insurer, which date shall be deemed the coverage date, the association may elect to succeed to the rights and obligations of the member insurer that accrue on or after the coverage date and that relate to policies, contracts or annuities covered, in whole or in part, by the association, under any one or more indemnity reinsurance agreements entered into by the member insurer as a ceding insurer and selected by the association, except that the association may not exercise an election with respect to a reinsurance agreement if the receiver, rehabilitator or liquidator of a member insurer has previously and expressly disaffirmed the reinsurance agreement. The election shall be effected by a notice to the receiver, rehabilitator or liquidator and to the affected reinsurers. If the association makes an election, then subparagraphs (A) to (D), inclusive, of this subdivision shall apply with respect to the reinsurance agreements selected by the association:

(A) The association shall be responsible for all unpaid premiums

due under the agreements for periods before, on and after the coverage date, and shall be responsible for the performance of all other obligations to be performed after the coverage date, in each case which relate to policies, contracts or annuities covered in whole or in part by the association. The association may charge policies, contracts or annuities covered in part by the association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the association.

(B) The association shall be entitled to any amounts payable by the reinsurer under the agreements with respect to losses or events that occur in periods after the coverage date and that relate to policies, contracts or annuities covered by the association in whole or in part, and upon the association's receipt of any such amount, the association shall pay any beneficiary **[**of a**]** under the policy, **[**or**]** contract or annuity under which the association paid only a portion of the policy, **[**or**]** contract or annuity amount:

(i) The amount received by the association that exceeds the benefits paid the beneficiary under the policy, contract or annuity; less

(ii) **[**the**]** The benefits paid by the association on account of the policy, **[**or**]** contract or annuity less the retention of the impaired or insolvent member insurer applicable to the loss or event.

(C) Not later than thirty days after the association's election, the association and each **[**indemnity**]** reinsurer shall calculate the net balance due to or from the association under each reinsurance agreement as of the date of the association's election with respect to policies, contracts or annuities covered, in whole or in part by the association, giving full credit to all items paid by either the member insurer or its receiver, rehabilitator or liquidator or the **[**indemnity**]** reinsurer during the period between the coverage date and the date of the association's election. Either the association or **[**indemnity**]**

reinsurer shall pay the net balance due the other not later than five days after the completion of the calculation. If the receiver, rehabilitator or liquidator has received any amounts due the association pursuant to subparagraph (B) of this subdivision, the receiver, rehabilitator or liquidator shall remit the same to the association as promptly as practicable.

(D) If the association or receiver, on behalf of the association, not later than sixty days after the election, pays the premiums due for periods before, on and after the coverage date that relate to policies, contracts or annuities covered by the association in whole or in part, the reinsurer shall not be entitled to terminate the reinsurance agreements insofar as the agreements relate to policies, contracts or annuities covered by the association in whole or in part and shall not be entitled to set off any unpaid premium due for periods prior to the coverage date against amounts due the association.

(2) If the association does not elect to assume a reinsurance contract by the date of the association election pursuant to subdivision (1) of this subsection, the association shall have no rights or obligations in each case for periods both before and after the date of the order of liquidation with respect to the reinsurance contract.

[(2)**]** (3) If the association transfers **[**its obligations**]** policies, contracts or annuities, or covered obligations with respect to such policies, contracts or annuities, to another assuming insurer, and if the association and the other insurer agree, the other insurer shall succeed to the rights and obligations of the association under subdivision (1) of this subsection, provided:

(A) The **[**indemnity**]** reinsurance agreements shall automatically terminate for new reinsurance unless the **[**indemnity**]** reinsurer and the other insurer agree to the contrary; **[**and**]**

(B) **[**the**]** The association's obligation to pay the beneficiary pursuant to subparagraph (B) of subdivision (1) of this subsection shall no longer apply on or after the date the **[**indemnity**]** reinsurance agreement is transferred to the **[**third party**]** assuming insurer; **[**This subdivision shall not apply if the association has previously expressly determined in writing that it will not exercise the election referred to in subdivision (1) of this subsection**]** and

(C) The transferring party shall give written notice to the affected reinsurer at least thirty days prior to the effective date of the transfer.

[(3)**]** (4) The provisions of this subsection shall supersede the provisions of any law of this state or of any affected reinsurance agreement that provides for or requires any payment of reinsurance proceeds on account of losses or events that occur in periods after the **[**coverage date**]** date of the order of liquidation, to the receiver, liquidator or rehabilitator of the insolvent member insurer or any other person. The receiver, rehabilitator or liquidator shall remain entitled to any amount payable by the reinsurer under the reinsurance agreement with respect to losses or events that occur in periods prior to the coverage date subject to applicable setoff provisions.

[(4)**]** (5) Except as otherwise expressly provided in this **[**subsection**]** section, nothing in this **[**section**]** subsection shall alter or modify the terms and conditions of the **[**indemnity**]** reinsurance agreements of the insolvent member insurer. Nothing in this section shall abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance agreement. Nothing in this section shall give a policy owner, contract owner, enrollee, certificate holder or beneficiary an independent cause of action against **[**an indemnity**]** a reinsurer that is not otherwise set forth in the **[**indemnity**]** reinsurance agreement. Nothing in this section shall limit or affect the association's rights as a creditor of an estate against the assets of the estate. Nothing in this section shall apply to reinsurance agreements covering property or

casualty risks.

(o) The board of directors of the association shall have discretion and may exercise reasonable business judgment to determine the means by which the association is to provide the benefits **[**of**]** under sections 38a-858 to 38a-875, inclusive, in an economical and efficient manner.

(p) Where the association has arranged or offered to provide the benefits **[**of**]** under sections 38a-858 to 38a-875, inclusive, to a covered person under a plan or arrangement that fulfills the association's obligations under sections 38a-858 to 38a-875, inclusive, the person shall not be entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

(q) Venue in a suit against the association arising under sections 38a-858 to 38a-875, inclusive, shall be in the superior court for the judicial district of Hartford. The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under sections 38a-858 to 38a-875, inclusive.

(r) In carrying out its duties in connection with guaranteeing, assuming, reissuing or reinsuring policies or contracts under subsections (a) or (b) of this section, the association may **[**, subject to approval of the receivership court,**]** issue substitute coverage for a policy or contract that provides an interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with subdivisions (1) to (3), inclusive, of this subsection:

(1) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for (A) a fixed interest rate, (B) payment of dividends with minimum

guarantees, or (C) a different method for calculating interest or changes in value;

(2) **[**there**]** There is no requirement for evidence of insurability, waiting period or other exclusion that would not have applied under the replaced policy or contract; and

(3) **[**the**]** The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

Sec. 7. Section 38a-866 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018, and applicable to impairments and insolvencies occurring on or after said date*):

(a) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such times and for such amounts as the board finds necessary. The association shall establish a due date for each assessment which shall be at least thirty days after the association has provided the member notice of the assessment. Each member insurer shall pay interest on any late payment at the rate of one per cent per month, or any portion thereof, from the due date to the date of payment.

(b) There shall be two classes of assessments, as follows:

(1) Class A assessments shall be made for the purpose of meeting administrative costs and other general expenses not related to a particular impaired or insolvent insurer; and

(2) Class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the association under section 38a-865, as amended by this act, with regard to an impaired or insolvent insurer.

(c) (1) The amount of any Class A assessment shall be determined by the board and may be authorized and called on a pro-rata or non-pro-rata basis. If an assessment is made on a pro-rata basis, the board may provide that the assessment be credited against future Class B assessments.

(2) (A) The amount of any Class B assessment, except for any assessment related to long-term care insurance, shall be allocated for assessment purposes **[**among**]** between the accounts and among the subaccounts of the life insurance and annuity account pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard that the board, in its sole discretion, deems as being fair and reasonable under the circumstances.

(B) The amount of the Class B assessment for long-term care insurance written by the impaired or insolvent insurer shall be allocated according to a methodology included in the plan of operation and approved by the commissioner. The methodology shall provide for fifty per cent of the assessment to be allocated to accident and health member insurers and fifty per cent to be allocated to life and annuity member insurers.

[(2)**]** (3) Class B assessments against member insurers for each account and subaccount shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account for the three most recent calendar years for which information is available preceding the year in which the member insurer became insolvent or, in the case of an assessment with respect to an impaired insurer, the three most recent calendar years for which information is available preceding the year in which the member insurer became impaired bear to such premiums received on business in this state for those calendar years by all assessed member insurers.

[(3)**]** (4) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be authorized or called until necessary to implement the purposes of sections 38a-858 to 38a-875, inclusive. Classification of assessments under subsection (b) of this section and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro-rata share of an authorized assessment that is not yet called not later than one hundred eighty days after the association authorizes the assessment.

(d) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

(e) (1) (A) Subject to the provisions of subparagraph (B) of this subdivision, the total of all assessments authorized by the association with respect to a member insurer for each subaccount of the life insurance and annuity account and for the health **[**insurance**]** account shall not in any one calendar year exceed two per cent of such insurer's average annual premiums received in this state on the policies and contracts covered by the subaccount or account during the three calendar years preceding the year in which the member insurer became an impaired or insolvent insurer.

(B) If two or more assessments are authorized in one calendar year with respect to member insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage shall be equal and limited to the higher of the three-year average annual premium for the applicable subaccount or account as calculated pursuant to this section.

(C) If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by sections 38a-858 to 38a-875, inclusive.

(2) The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(3) If the maximum assessment for any subaccount of the life insurance and annuity account in any one year does not provide an amount sufficient to carry out the responsibilities of the association, then pursuant to subdivision **[**(2)**]** (3) of subsection (c) of this section, the board shall access the other subaccounts of the life insurance and annuity account for the necessary additional amount, subject to the maximum stated in subdivision (1) of this subsection.

(f) The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each member insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, net realized gains and income from investments. A reasonable amount may be retained in any account to

provide funds for the continuing expenses of the association and for future losses if refunds are impractical.

(g) It shall be proper for any member insurer, in determining its premium rates and policy owner dividends as to any kind of insurance or health care center business within the scope of sections 38a-858 to 38a-875, inclusive, to consider the amount reasonably necessary to meet its assessment obligations under said sections.

(h) (1) Each member insurer paying an assessment under sections 38a-858 to 38a-875, inclusive, may offset one hundred per cent of the amount of such assessment against its premium tax liability to this state under chapter 207. Such offset shall be taken over a period of the five successive tax years following the year of payment of the assessment, at the rate of twenty per cent per year of the assessment paid to the association. Each member insurer to which has been refunded by the association, pursuant to subsection (f) of this section, all or a portion of an assessment previously paid to the association by the member insurer shall be required to pay to the Department of Revenue Services an amount equal to the total amount that has been claimed as an offset against the premiums tax liability on the premiums tax return or returns, as the case may be, filed by such insurer and that is attributable to such refunded assessment, provided the amount required to be paid to said department shall not exceed the amount of the refunded assessment. If the amount of the refunded assessment exceeds the total amount that has been claimed as an offset against the premiums tax liability on the premiums tax return or returns filed by such member insurer and that is attributable to such refunded assessment, such excess may not be claimed as an offset against the premiums tax liability on a premiums tax return or returns filed by such insurer or, if the offset has been transferred to another person pursuant to subdivision (2) of this subsection, by such other person. For purposes of this subdivision, if the offset has been

transferred to another person pursuant to subdivision (2) of this subsection, the total amount that has been claimed as an offset against the premiums tax liability on the premiums tax return or returns filed by such insurer includes the total amount that has been claimed as an offset against the premiums tax liability on the premiums tax return or returns filed by such other person. The association shall promptly notify the Commissioner of Revenue Services of the name and address of the member insurers to which such refunds have been made, the amount of such refunds, and the date on which such refunds were mailed to each such insurer. If the amount that **[**an**]** a member insurer is required to pay to the Department of Revenue Services has not been so paid on or before the forty-fifth day after the date of mailing of such refunds, the insurer shall be liable for interest on such amount at the rate of one per cent per month, or fraction thereof, from such forty-fifth day to the date of payment.

(2) **[**An**]** A member insurer, in this subdivision called "the transferor", may transfer any offset provided under subdivision (1) of this subsection to an affiliate, as defined in section 38a-1, of the transferor. Any such transfer of the offset by the transferor, and any subsequent transfer or transfers of the same offset, shall not affect the obligation of the transferor to pay to the Department of Revenue Services any sums which are acquired by refund from the association pursuant to subsection (f) of this section and which are required to be paid to the Department of Revenue Services pursuant to subdivision (1) of this subsection. Such offset may be taken by any transferee only against the transferee's premium tax liability to this state under chapter 207. The Commissioner of Revenue Services shall not allow such offset to a transferee against its premium tax liability unless the transferor, the affiliate to which the offset was originally transferred, each subsequent transferor and each subsequent transferee have filed such information as may be required on forms provided by said commissioner with respect to any such transfer or transfers on or

before the due date of the premium tax return on which such offset would have been taken by the transferor, if no transfer had been made by the transferor.

(i) (1) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment shall be available to meet association obligations during the pendency of the protest or any subsequent appeal. Payment shall be accompanied by a written statement that (A) the payment is made under protest, and (B) includes a brief statement of the grounds for the protest.

(2) Not later than sixty days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

(3) Not later than thirty days after a final decision has been made, the association shall notify the protesting member insurer in writing of the final decision.

(4) Not later than sixty days after receipt of notice of the final decision, the protesting member insurer may appeal the final action to the commissioner.

(5) In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the commissioner for a final decision, with a recommendation from the association.

(6) If the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member **[**company**]** insurer. Interest on a refund due a protesting member insurer whose protest or appeal was upheld shall be paid at the rate actually earned

by the association.

(j) The association may request information from member insurers in order to aid in the exercise of its power under this section and member insurers shall promptly comply with such request.

Sec. 8. Section 38a-871 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018, and applicable to impairments and insolvencies occurring on or after said date*):

(a) Nothing in sections 38a-858 to 38a-875, inclusive, shall be construed to reduce the liability for unpaid assessments of the insureds of an impaired insurer operating under a plan with assessment liability.

(b) Records shall be kept of all negotiations and meetings in which the association or its representatives are involved to discuss the activities of the association in carrying out its powers and duties under section 38a-865, as amended by this act. Records of such negotiations or meetings shall be made public only upon the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired insurer, upon the termination of the impairment of the insurer, or upon the order of a court of competent jurisdiction. Nothing in this subsection shall limit the duty of the association to render a report of its activities under section 38a-872.

(c) For the purpose of carrying out its obligations under sections 38a-858 to 38a-875, inclusive, the association shall be deemed to be a creditor of the impaired insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to subdivision (i) of section 38a-865, as amended by this act. All assets of the impaired insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired insurer as required by

sections 38a-858 to 38a-875, inclusive. Assets attributable to covered policies or contracts, as used in this subsection, is that proportion of the assets which the reserves that should have been established for such policies or contracts bear to the reserve that should have been established for all policies or contracts of insurance or health care center subscriber contracts and certificates written by the impaired or insolvent insurer.

(d) (1) Prior to the termination of any liquidation, rehabilitation or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, contract owners, certificate holders, enrollees and **[**policyowners**]** policy owners of the **[**impaired**]** insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of such **[**impaired**]** insolvent insurer. In such a determination, consideration shall be given to the welfare of the **[**policyholders**]** policy holders, contract owners, certificate holders and enrollees of the continuing or successor member insurer.

(2) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of **[**assessments levied by the association with respect to such insurer has been fully recovered by the commission**]** valid claims of the association with interest thereon for funds expended in carrying out its powers under section 38a-865, as amended by this act, with respect to the member insurer have been fully recovered by the association.

(e) It shall be a prohibited unfair trade practice and a violation of section 38a-815 for any person to make use in any manner of the protection afforded by sections 38a-858 to 38a-875, inclusive, in the solicitation, negotiation, procurement or effectuation of insurance provided, this subsection shall not apply to the distribution of any publication approved by the commissioner and describing the general

purposes and current limitations of sections 38a-858 to 38a-874, inclusive. Violations of this section shall be subject to the provisions of section 38a-817.

(f) (1) If an order for liquidation or rehabilitation of **[**an**]** a member insurer domiciled in this state has been entered, the receiver appointed under such order shall have a right to recover on behalf of the member insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the member insurer on its capital stock, made at any time during the five years preceding the petition for liquidation or rehabilitation subject to the limitations of subdivisions (2) to (4), inclusive, of this subsection.

(2) No such dividend shall be recoverable if the member insurer shows that **[**when paid**]** the distribution was lawful and reasonable when paid, and that the member insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the member insurer to fulfill its contractual obligations.

(3) Any person who was an affiliate that controlled the member insurer at the time the distributions were paid shall be liable up to the amount of distributions **[**he**]** such person received. Any person who was an affiliate that controlled the member insurer at the time the distributions were declared shall be liable up to the amount of distributions **[**he**]** which such person would have received if **[**they**]** such person had been paid immediately. If two persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(4) The maximum amount recoverable under this subsection shall be the amount needed in excess of all other available assets of the **[**impaired**]** insolvent insurer to pay the contractual obligations of the **[**impaired**]** insolvent insurer.

(5) If any person liable under subdivision (3) of this subsection is insolvent, all its affiliates that controlled it at the time the dividend was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

Approved May 25, 2018